



GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT



Jed Ross
Chief Risk Officer

Public Sector Workers'
Compensation Program

EMPLOYEE CLAIM FOR PERMANENT DISABILITY COMPENSATION

Use this form to file a claim for a schedule award for permanent disability compensation pursuant to D.C. Code § 1-623.07 with the District of Columbia Public Sector Workers' Compensation Program (PSWCP).

READ INSTRUCTIONS HERE AND ON THE REVERSE SIDE

You **MUST** complete Sections I and II of this form in their *entirety*. Please submit **with this form** any necessary attachments. Section III must be completed by a qualified physician with specific training and experience in the use of the most recent edition of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment at the time of submission and shall be accompanied by any medical records, report, or evidence that support any rating. *If as of April 25, 2020 you received 448 weeks or more of temporary indemnity compensation, your request should be filed with the Office of Administrative Hearing on Form 9, NOT this form.*

SECTION I. To be completed by Claimant or Representative.

Claimant's Name: _____
Claimant's Full Address (with unit number, zip code): _____

Representative (if any): _____
Rep.'s Full Address (with unit number, zip code): _____

Claimant's Telephone: _____
Claimant's E-mail: _____
Claim Number: _____
Date of Birth: _____
Social Security No.: _____
Temporary Indemnity
Benefits Started: _____
(date)

Rep.'s Telephone: _____
Rep.'s Fax: _____
Rep.'s E-mail: _____
Date of Injury: _____
Employing Agency: _____
Temporary Indemnity
Benefits Ended: _____
(date)

SECTION II. To be completed by Claimant. Circle YES or NO in response to ALL questions in this section.

- | | | |
|--------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Did you receive temporary disability indemnity compensation for this injury? | YES | NO |
| 2. Has a qualified physician documented that you have reached maximum medical improvement for your disability? | YES | NO |
| 3. Did you suffer the loss of both hands, both arms, both feet, or both legs, or sight in both eyes as a result of your work injury? | YES | NO |
| 4. Have you ever filed a claim for permanent disability in the past? | YES | NO |

➔ ➔ **TURN OVER TO CONTINUE** ➔ ➔

441 Fourth Street, NW, Suite 800 South | Washington, DC 20001 | Tel: (202) 727-8600 | <http://orm.dc.gov/>

5. Has 181 days or more past since you last received any temporary disability indemnity compensation payment? (If yes, explain good cause for the delay in submitting Form 12 and attach proof.) YES NO

CERTIFICATION: I have read this form and I swear or affirm that the contents are true and accurate to the best of my knowledge.

Print Name Signature Date

SECTION III. To be completed by Physician. *Physician's medical report in support of the following opinions must be attached and submitted with this request.*

A. Doctor's Information:

Name: Practice Name:
Office Address: Office Phone No.:
Office Fax No.:

B. Diagnosis or Nature of Disease or Injury

Enter ICD 10 Code	ICD10 Description
(1)	
(2)	
(3)	
(4)	

C. Maximum Medical Improvement

Has the patient reached Maximum Medical Improvement (MMI)? YES NO
If yes, please provide date patient reached MMI:

D. Permanent Impairment

Is there a permanent impairment? YES NO

Schedule loss of use of member of facial disfigurement. (Identify impairment rating according to the latest AMA Guidelines and attach separate sheet for additional body parts).

Body Part:	Impairment %:
Body Part:	Impairment %:
Body Part:	Impairment %:

Describe findings and relevant diagnostic test results:

(attach medical records, evidence or report in support of findings)

E. Health Care Provider Certification: Signed under penalty of perjury.

Name Signature Specialty Date

Claimant **MUST** file this claim for permanent disability by mail or in person with the PSWCP at the District of Columbia Office of Risk Management between the hours of 9:00 a.m. and 5:00 p.m. at:

**Office of Risk Management
One Judiciary Square
441 Fourth Street, N.W., Suite 800 South
Washington, DC 20001-2714**